



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

COLUMBIA RIO GRANDE REGIONAL HOSPITAL

Respondent Name

PHARR SAN JUAN ALAMO ISD

MFDR Tracking Number

M4-98-A268

Carrier's Austin Representative

Box Number 01

MFDR Date Received

February 18, 1998

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "the guidelines for inpatient acute care have been held to be void and unenforceable by the Supreme Court of Texas. Therefore the carrier's adoption of the same, if the carrier is adopting the same are likewise void and unenforceable. . . . In light of the above the provider asserts it is owed the usual and customary charges or the full amount of the bill. At the least the carrier owes 80% of the total charges pursuant to the 'old law'."

Amount in Dispute: \$2,782.53

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "we are standing by our initial audit. For the date in question, HealthSmart had adopted the 'ratio' as fair and reasonable. Therefore, the audit stands as is."

Response Submitted by: CorVel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 9, 1997 to June 14, 1997	Inpatient Hospital Services	\$2,782.53	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §141.1 sets out procedures for requesting a benefit review conference.

Issues

1. What is the rule for determining reimbursement of the disputed services?
2. Has the requestor supported that additional reimbursement is due?

Findings

1. This dispute relates to inpatient hospital services. The former agency's *Acute Care Inpatient Hospital Fee Guideline* at 28 Texas Administrative Code §134.400, 17 *Texas Register* 4949, was declared invalid in the case of *Texas Hospital Association v. Texas Workers' Compensation Commission*, 911 *South Western Reporter Second* 884 (Texas Appeals – Austin, 1995, writ of error denied January 10, 1997). As no specific fee guideline existed for acute care inpatient hospital services during the time period that the disputed services were rendered, the 1991 version of 28 Texas Administrative Code §134.1(f) applies as the proper Division rule to address fee payment issues in this dispute, as confirmed by the Court's opinion in *All Saints Health System v. Texas Workers' Compensation Commission*, 125 *South Western Reporter Third* 96 (Texas Appeals – Austin, 2003, petition for review denied). 28 Texas Administrative Code §134.1(f), effective October 7, 1991, 16 *Texas Register* 5210, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, sec. 8.21(b), until such period that specific fee guidelines are established by the commission."

The former Texas Workers' Compensation Act section 8.21 was repealed, effective September 1, 1993 by Acts 1993, 73rd Legislature, chapter 269, section 5(2). Therefore, for services rendered on or after September 1, 1993, the applicable statute is the former version of Texas Labor Code section 413.011(b), Acts 1993, 73rd Legislature, chapter 269, section 1, effective September 1, 1993, which states:"

Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission shall consider the increased security of payment afforded by this subtitle.

2. In the following analysis, the requestor's position and supporting documentation are reviewed to determine if the amount sought by the requestor would provide a fair and reasonable reimbursement for the services in dispute. The requestor has the burden of proof. The standard of proof required is by a preponderance of the evidence. If the requestor meets this burden, then the respondent's position and supporting documentation will be reviewed to determine whether the amount the insurance carrier has paid is a fair and reasonable rate of reimbursement.

Review of the submitted documentation finds that:

- The requestor's position statement asserts, "the guidelines for inpatient acute care have been held to be void and unenforceable by the Supreme Court of Texas. Therefore the carrier's adoption of the same, if the carrier is adopting the same are likewise void and unenforceable. . . . In light of the above the provider asserts it is owed the usual and customary charges or the full amount of the bill. At the least the carrier owes 80% of the total charges pursuant to the 'old law'."
- The Division notes that former Division rule at 28 Texas Administrative Code §42.110(b)(2) is not applicable to the services in dispute. As noted above, the 1991 version of 28 Texas Administrative Code §134.1(f) applies as the proper Division rule to address fee payment issues in this dispute, as confirmed by the Court's opinion in *All Saints Health System v. Texas Workers' Compensation Commission*, 125 *South Western Reporter Third* 96 (Texas Appeals – Austin, 2003, petition for review denied).
- The Division finds that a reimbursement methodology based upon payment of a hospital's billed charges, or a percentage of billed charges, does not produce an acceptable payment amount in the absence of other documentation or data to support that the amount requested is fair and reasonable. Such a reimbursement methodology would leave the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also fails to provide incentive to contain medical costs. Therefore, a reimbursement amount that is calculated based on a hospital's billed charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.

- The requestor did not present documentation or data to support that their usual and customary charges represent a fair and reasonable rate of reimbursement for the services in dispute.
- The requestor did not present documentation or data to support that payment of 80 percent of their usual and customary charges would result in a fair and reasonable rate of reimbursement for the services in dispute.
- The requestor does not discuss or explain how payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

	Grayson Richardson	September 30, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MFDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of this *Medical Fee Dispute Resolution Findings and Decision*, together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.